UTAH MEDICAID REFORM BILL – S.B. 180
DISCUSSION IOF 1115 WAIVER – MEDICAID REFORM PRINCIPLES
PROVIDER FOCUS MEETING – CAPITATED RATE SETTING PROCESS AND DATA REQUIREMENTS
APRIL 20, 2011 – CANNON HEALTH BUILDING ROOM 125
3:30-5:00 P.M.

Attendees: Michael Hales, Rod Betit, Gordon Crabtree, Mark Brown, Sean Dunroe, Julie Day, Casey Hill, Lincoln Nehring, Collin Davis, Russ Elbel, Barb Viskochil, Byron Okutsu, Alan Pruhs, Lisa Nichols, Jesse Liddell, Jim Murray, Todd Wood, Doug Burton, Kevin Moffitt, Patrick Fleming, Representative Dean Sanpei, Kris Fawson, Ross VanVranken, John Grima, Bob Parker, Nate Checketts, Curt Peterson, M.D., Emma Chacon, Emily Sullivan, Denise Love, Doug Thomas, Gail Rapp, John Curless, Blake Anderson, Amy Bingham, Randy Baker, Sheila Walsh-McDonald, Gayle Coombs

Michael called the meeting to order at 3:35 p.m. He said that one request has been made that we have the primary focus of the discussion participants around the table and at least have enough room around the table for the providers to be here or the client representatives during those discussions. Michael mentioned the sign-in sheet that is passed around to everyone. He thanked everyone for their interest and on-going participation in these discussions.

Michael said the topic today is the capitated rate setting process and data requirements that we will be setting. This will be for the new Accountable Care Organizations (ACOs). Michael said that currently the Department of Health (DOH) only has one contract that is a full-capitation module. That contract is with Molina. Michael explained the process that we currently go through in setting the capitated rates with Molina. He said right now we use two years of historical data. We get a comparative score for the individuals enrolled. Michael mentioned some of the factors they look at in regard to this. Michael mentioned some problems we have with the current rate setting process.

Michael mentioned how we want to have the same pool of money available for the contracts. Michael mentioned a number of factors that we have to take into account as we look at this. They want to be sure the rates are in line with the services that are provided. The rates need to meet the CMS criteria, and this is checked on by the actuaries. Michael said they have a range of high and low of what they are willing to establish.

Michael said on the other hand, we want to alleviate some of the things the ACOs have to do with this. He mentioned that the diagnostic codes are looked at in regard to this. Michael said we have asked our contracted actuaries to write up some of their thoughts in regard to this. Michael said we are recommending that we don't have to collect the amount shown in the system. He said we are interested in gathering enough information about the clients so that we can adjust their risk within the population and establish a justifiable rate. Michael said that encounter data compared to cost data may be a little different.

Gordon Crabtree had some comments on this. Michael answered Gordon's question. He said we would start with all the money associated with the clients and look at everything we are paying for them. This would be the cost assumptions on how the base is started. Michael said they are essentially looking at historical expenditures in these three plans, including three different categories. Michael said he does not think we will have a problem coming up with the initial rates. He mentioned how the actuaries do try to advise the state on how these rates should be set up. Michael said there could be an adjustment in regard to some of the clients. He mentioned different things that we are going to have to be looking at in regard to this proposal. He mentioned the three

things that Milliman put in the document on how they interact with CMS. One of the things is that these funds will have to be used only for Medicaid clients.

Michael said if this venture is successful, people may want to replicate it, so we want to be sure that we keep all the details on this. Michael said our starting point with CMS would be to provide them with encounter data that the providers performed. Michael said we are really looking at a capitated payment system that can be sub-capitated to different providers.

Michael mentioned encounter data. He said the actuaries are recommending that we use a July 1, 2012 implementation date if CMS approves the waiver on a timely basis. For calendar year 2011, that would be pulling all the claims for this calendar year and looking at all the claims. Michael said that since this is a new kind of contracting, they are recommending that six months into 2012 we would update it again with more information and have new rates in place for the other six months in that year. Michael said we have seen about a 12% growth rate this year. Last year there was a 14% growth rate and the year before that there was a 19% growth rate.

Gordon said he felt risks could be reduced if we could do this. Mark Brown also mentioned that he agreed with this, but he said they would like to see the details. Michael said we are not anticipating any changes in regard to those coming on to the program. He said we are trying to use as much of our existing infrastructure as we can.

Representative Sanpei said that in 2014 things would change. Michael said that we may not do rebase in January of 2014. Michael said that could be a big risk. He said that depending on how the contract is structured would determine where the biggest risk would be. Michael said we will want to work very closely with the plans to set these rates.

A question on how often the eligibility is recertified was asked. Michael explained different things that can make this happen. He explained how often DWS does reviews in regard to a person's eligibility. Michael said we would want to keep the same processes in regard to plan switch that we now use.

A question was asked on how some things are related to the encounter data. Michael mentioned some of the things that we might have to look at in regard to this. On the payment side, that would be more of a contractual issue with the plan. Michael mentioned different things they will have to look at in regard to the different risk plans. It was asked where the data will come from that will be submitted to the actuaries. Will it come from the state or from the plan itself? Michael explained how Molina submits their claims now and said we then submit these to the actuaries.

Michael said we would like more frequent adjustment early on. He said we will still pretty much have a six-month lag. It was asked if you classified the claims by eligibility or by diagnosed condition. Michael mentioned there are a number of rate cells, but they are based on Medicaid levels of eligibility. He went over the different levels of eligibility that Medicaid now has, which are shown below:

Children ages zero to one
Individuals with children one through eighteen years of age
Nineteen to sixty-four year old population with a more limited benefits package
Dually eligible population, ages sixty-five and older
Individuals with disabilities of all ages
Breast and cervical cancer clients of all ages
Pregnant women
Restricted population

Tech Dependent Waiver category

Michael said these are the broad categories. He said mental health services are covered an entirely different waiver. Michael said rate cells are an easier move for the DOH. The rate cells would be their starting point. Various comments were made in regard to this. Michael said we will have to evaluate the different rates in regard to this.

Michael said we just want to be sure that the ACOs can do the following things:

Demonstrate ability to bear and manage risk and distribute payments across the continuum,
Meet the credentialing standards,
Meet those criteria and certify to the state that they meet those criteria as a condition of contract in the future.

Michael said these are the key issues.

Michael said he does not feel any ACO would have to guarantee that they would provide services in all four counties. Certification in regard to NCQA was mentioned, and Michael said that the ACOs would have to at least be working towards that. He said that each ACO will have to provide information to the state that they meet the criteria. Michael said we want to be sure that the people on the plan will be getting the proper services that they need. We will want assurance of that.

Michael said we are looking at this on what would meet our standard points and what CMS would approve. Michael mentioned what will be discussed in the May 11th meeting.

Rod Betit asked if there would be a possibility for the DOH to have a stop loss in case the ACO's were losing a lot of money. Michael said we would be willing to explore that but would have to hold back from the initial rates. Different comments were made in regard to this. Rod also had a question in regard to transplants and how this would be covered. Gail Rapp said Molina is at full risk for the transplants but Healthy U is not. It would just depend on their contract. Various comments were made in regard to this. Barbara Viskochil mentioned that somebody in need of a transplant usually becomes Medicare eligible. Michael said this will be a negotiated arrangement with the different ACO's.

A question was asked in regard to administrative fees and services. Michael mentioned different things that they will look at in regard to this. Michael said our concern is still the renewal rates. He mentioned different challenges in regard to this. Michael said one of the key issues of the plan is not to penalize the plans for providing the services in the best way they can.

The legislation in regard to the growth rate funds was mentioned. Representative Sanpei said the rate of the budget is tied to the member per month. He said they don't want to reduce the amount that is paid out but curve it out some. The rates will be tied to the per member per month.

Michael mentioned an alternative cost structure that could be included for the actuaries.

Transportation payments would remain a carved out service. Michael said if the plans thought they could do any of the carved out services at a cheaper rate, this could be looked at. This would not include mental health services, however. Different things that would be involved if mental health was moved into this were mentioned. Mental health drugs, including anti-psychotics and psychotropics were discussed. Michael said right now none of our contracts with the ACOs would have anything to do with mental health pharmaceuticals.

Representative Sanpei said this will be a high priority as we move forward. He said that he feels we will have to start with this as a carve out. Michael said the big issue will be figuring out which drugs will be considered exempt. He said we would need to get some clarification and agreement on this in putting these on a Preferred Drug List.

Michael then gave a brief summarization of what was discussed today. He mentioned different things they will be taking into consideration with the actuaries.

He said we will continue to do more frequent updates in regard to the risk adjustments going into the first two years of this on a six-month time table or our actuaries may have us looking at these six months into the contract. He said we will definitely be taking into consideration with our actuaries how we might be able to work with the historical base and include distribution payments that would be easy to substantiate in terms of the dollar amount. That would alleviate our need to have to see a downward expenditure trend possibly as a result. Michael said that we would plan on collecting encounter data that would include diagnostic codes and procedures that you have delivered and not gathered the expenses, and then look for ways that we would be able to somehow recognize non-traditional services.

Representative Sanpei said he felt the stop loss should be included in this.

Michael thanked everyone for their time today and mentioned that the topic for the meeting next week will be client incentives for healthy behaviors. Michael said they would like suggestions from the plans to be included in the waiver in regard to cost-sharing incentives.

The meeting adjourned at 5:00 p.m.